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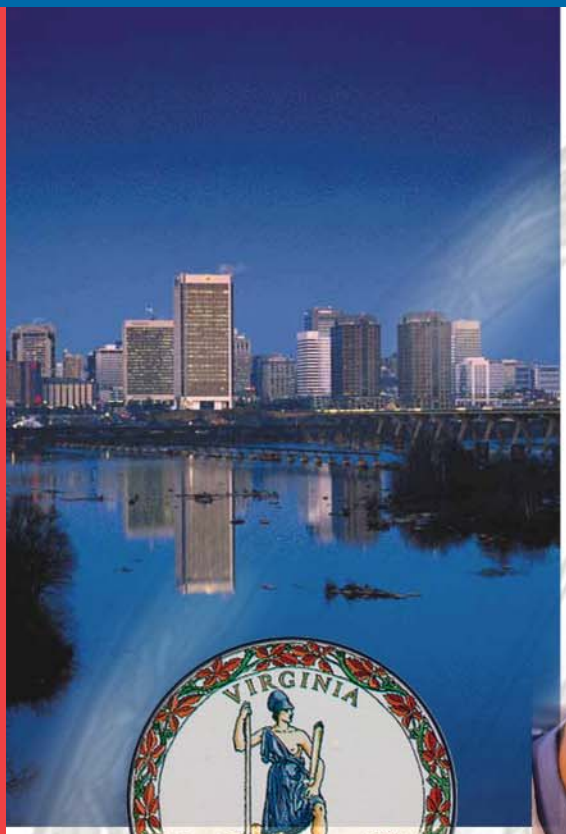

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Southern Health Services/CareNet

Annual Report CY 2005

Improving Healthcare in the Communities We Serve.

Southern Health Services/CareNet Annual Report

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

Following federal requirements for an annual assessment, as set for the in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of MCO Name to assess the MCO's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition

of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the progress that medallion II managed care plans have made in fulfilling the foals of DMAS. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

Although Delmarva's task is to assess how well Southern Health Services/CareNet (CareNet) performs in the areas of quality, access, and timeliness from Health Employer Data and Information Set (HEDIS®[1]) performance, performance improvement projects (PIPs), and operational systems review perspective, it is important to note the interdependence of quality, access, or timeliness also may be noted under either of the other two areas.

Quality, access and timeliness of care expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report.

Background on Plan

CareNet provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia, specifically in the Central Virginia region. Enrollment in 2005 for CareNet health plan was 16,277 members. CareNet began providing services to Medallion II enrollees in April 1996 and is an NCQA accredited health plan with an excellent accreditation status.

Data Sources

Delmarva used three major data sources to evaluate the CareNet's performance:

- HEDIS, which is a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.
- Summaries of plan-conducted Performance Improvement Projects.
- Operational Systems Review, consisting of a pre-site and on-site review.

[1] HEDIS ®is a registered trademark of the National Committee for Quality Assurance.

Methodology

Delmarva performed an external independent review of all data from the three sources above. The EQRO has assessed quality, access, and timeliness across the three data disciplines. After discussion of this integrated review, Delmarva will provide an assessment to DMAS regarding how well the health plan is providing quality care and services to its members.

The BBA requires that performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Audits are to be conducted as prescribed by NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*[2] and is consistent with the validation method required by the EQRO protocols. Each Medallion II MCO uses NCQA protocols, including the Data Submission Tool (DST) to capture and compute its HEDIS results. The HEDIS data in this report have been taken directly from the Data Submission Tool (DST) completed by each MCO, but were not audited by Delmarva. This report contains data results of common HEDIS measures, each of which was calculated by all Medallion II managed care plans.

During the HEDIS 2006 reporting year, Medallion II MCOs collected data from calendar year 2005 related to the following clinical indicators as an assessment of quality, access, and timeliness:

- Childhood Immunization Status.
- Adolescent Immunization Status.
- Breast Cancer Screening.
- Prenatal and Postpartum Care.
- Well-Child Visits in the First 15 Months of Life.
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life.
- Adolescent Well-Care Visit.

PIPs also are used to assess the health plan's focus on quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to issues of access or timeliness as major contributing factors that affect the attainment of the clinical quality goals. During 2004, each MCO implemented two PIPs, aimed at addressing clinical issues pertinent to the health plan's population. Delmarva reviewed the health plan's PIPs, assessed compliance with DMAS contractual requirements, and validated the activity for interventions as well as evidence of improvement. The baseline year for PIPs was 2004 and therefore evidence of improvement was not assessed in the last review, but will be assessed for the 2005 review. The PIP topics were as follows:

[2]The NCQA *HEDIS Compliance Audit*™ is a trademark of NCQA.

- Improving Overall Treatment and Utilization Patterns for the Health Management Asthma Population.
- Improving Adolescent Immunization Status.

CareNet's Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq*. In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation.
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation.
- Grievance Systems (GS)—Subpart F Regulation.

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Only those elements that were not fully met in the 2003 review were assessed as part of the calendar year (CY) 2004 review. The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Quality at a Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program.

Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population. The findings related to quality are reported in the following sections.

HEDIS

Three HEDIS measures served as proxy measures for clinical quality:

- Childhood Immunizations.
- Adolescent Immunizations.
- Breast Cancer Screening.

The HEDIS 2005 results are presented in Table 1 below.

Table 1. Measures of Quality –Childhood Immunization Status, Adolescent Immunization Status, and Breast cancer Screening Rates*

Measure	CareNet	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Childhood Immunization Status Combination 2	67.7%	68.1%	62.9%
Adolescent Immunization Status Combination 2	26.1%	34.5%	38.4%
Breast Cancer Screening	44.5%	52.6%	54.0%

*Data in this table was submitted by the MCO and not validated by Delmarva.

CareNet exceeded the HEDIS 2005 National average for the Childhood Immunization Status measure. CareNet's Adolescent Immunization status rate (26.1%) and Breast Cancer Screening rate also fell below the Medallion II and the HEDIS 2005 National Medicaid Average. While the Childhood Immunization Status Measure exceeds the HEDIS 2005 National Medicaid Average, there is still room for improvement for all three measures. It is therefore recommended that CareNet continue its participation with the other Medallion MCOs in the collaborative project to improve immunization rates. It is also recommended that CareNet further investigate the need for a project on breast cancer screening or at a minimum conduct a barrier analysis.

Performance Improvement Projects

CareNet appropriately used the quality process of Performance Improvement Projects (PIPs) to identify a problem relevant to their health plan population. The PIP process also required setting a measurement goal,

obtaining a baseline measurement, and performing targeted interventions aimed at improving the performance. After the remeasurement periods, qualitative analyses often identified new barriers that affect success in achieving the targeted goal. Thus, quality improvement is an ever-evolving process focused on improving outcomes and health status.

As in the 2004 review, all MCOs conducted a PIP targeting their population receiving treatment for asthma in 2005. This is an MCO system-wide initiative (enrollee, provider, and administrative) that presents potential barriers to improved enrollee health outcomes. Each MCO chose study indicators and data collection procedures that were based upon HEDIS measures and specifications.

A focus on asthma by each of the MCOs addresses an important opportunity for improvement in the member population based on review of Medicaid HMO plan-specific and national data. Asthma ranked in the top diagnoses for MCO inpatient admissions, emergency department visits, and outpatient office visits.

CareNet implemented a PIP directed at improving adolescent immunization status. This is an appropriate topic for selection based on the HEDIS results presented in the section above. Since 2004 was considered a baseline year for submission of the second PIP, improvement was not assessed in the last annual review. For CareNet, 2005 data for the Adolescent Immunization PIP was taken from the Data Submission Tool provided by the MCO. The data were not validated by Delmarva, but have been included in the table below for analysis.

Performances on the PIPs are summarized in Table 2 below.

Table 2. PIP Performance Results for CareNet*

PIP Activity	Indicator	Baseline	Remeasurement					
			#1	#2	#3	#4	#5	#6
CareNet		2004	2005					
Increasing the Number of Members With Asthma to Receive Care According to the Guidelines	**Quantifiable Measure #1:** Percent of eligible asthma members who had an influenza vaccination in the measurement year.	31.3%	18.4%					
	Quantifiable Measure #2: Percent of eligible asthma members who had an acute hospital admission in the measurement year.	11.4%	9.7%					
	Quantifiable Measure #3: Percent of eligible asthma members who had an acute ER visit in the measurement year.	33.1%	39.0%					

PIP Activity	Indicator	Baseline	Remeasurement					
			#1	#2	#3	#4	#5	#6
		2004	2005					
Increasing Adolescent Immunization Rates – Medicaid+	**Quantifiable Measure #1:** The percentage enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday, and who were identified as having a second dose of MMR by the member's 13th birthday.	57.33%	55.7%					
	Quantifiable Measure #2: The percentage enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday, and who were identified as having three Hepatitis B Vaccines by the member's 13th birthday.	56.25%	55.2%					
	Quantifiable Measure #3: The percentage enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday, and who were identified as having had one varicella vaccine by the member's 13th birthday.	24.7%	30.8%					
	Quantifiable Measure #4: The percentage enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday, and who were identified as having had a second	43.5%	*					

PIP Activity	Indicator	Baseline	Remeasurement					
			#1	#2	#3	#4	#5	#6
	dose of MMR and three Hepatitis B vaccines by the member's 13th birthday.							
	Quantifiable Measure #5: The percentage enrolled adolescents who turned 13 years old during the measurement year, were continuously enrolled for 12 months immediately prior to their 13th birthday, and who were identified as having had a second dose of MMR, three hepatitis B, and one varicella vaccine , by the member's 13th birthday (combo 2).	20.38%	26.1%					

*This measure has been retired from the HEDIS measure set.
+ Rates for this project were taken from the Data Submission Tool submitted by the MCO. These rates were not validated by Delmarva.

An understanding of the quality improvement process, as it relates to PIPs, was evidenced by CareNet as documented in its project submissions. The asthma PIP includes the three indicators in Table 2 above. CareNet experienced a decrease from the baseline rate of 31.3% to 18.4% in 2005 for the influenza vaccination measure. The second measure, members with asthma who had an acute hospital admission, decreased from 11.4% in the baseline period to 9.7% in 2005. This is positive improvement in the indicator. The final measure, members with asthma who had an acute ER visit increased from 33.1% in the baseline period to 39.0% in the 2005, which is not a positive improvement. Overall, CareNet achieved a positive improvement in one project indicator from the baseline period; acute hospitalizations for members with a primary diagnosis of asthma.

The Increasing Adolescent Immunization Rate project was submitted as the additional PIP required for the 2004 review. Interventions implemented in the review year included primarily member and provider newsletters while one intervention involved partnering with the State's Health Immunization Registry for data sharing These rates indicate that the rate for the second dose of MMR decreased from 57.3% in 2004 to 55.7% in 2005. The rate for 3 Hepatitis B immunizations also decreased slightly from 56.25% in 2004 to 55.2% in 2005. However, the Varicella indicator increased from 24.7% to 30.8% from 2004 to 2005. The increase in the Varicella indicator contributed to the overall increase in the Combination 2 rate (2 doses of MMR, 3 Hepatitis B, and one Varicella) from 20.38% in 2004 to 26.1% in 2005.

Operational Systems Review

The standards that pertain to quality and were used to assess the Medallion II MCOs performance in the area of quality are listed below.

Enrollee Rights and Protections—Subpart C Regulations.

- ER.1. Enrollee Rights and Protections-Staff/Provider.
- ER.6. Advanced Directives.

Quality Assessment and Performance Improvement—Subpart D Regulations.

- QA3. 438.206 Availability of Services (b) (3).
- QA5. 438.206 (c) (2) Cultural Considerations.
- QA6. 438.208 Coordination and Continuity of Care.
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests.
- QA15. 438.214 (b) Provider Selection—Credentialing and Recredentialing Requirements.
- QA16. 438. 214 (c) Provider Selection—Nondiscrimination.
- QA17. 438.12 (a, b) Provider Discrimination Prohibited.
- QA18. 438.214 (d) Provider Selection—Excluded Providers.
- QA19. 438.56 (b) Provider Enrollment and Disenrollment—Requested by MCO.
- QA20. 438.56 (c) Provider Enrollment and Disenrollment—Requested by Enrollee.
- QA21. 438.228 Grievance Systems.
- QA22. 438.230 Sub contractual Relationships and Delegation.
- QA23. 438.236 (a, b) Practice Guidelines.
- QA24. 438.236 (c) Dissemination of Practice Guidelines.
- QA25. 438.236 (d) Application of Practice Guidelines.
- QA26. 438.240 Quality Assessment and Performance Improvement Program.
- QA27. 438.240 (b) (2) Basic Elements of Quality Assessment and Performance Improvement (QAPI) Program—Under/Over Utilization of Services.
- QA28. 438.240 (b) (3) Basic Elements of QAPI Program—Special Health Care Needs.
- QA29. 438.242 Health/Management Information Systems.

Grievance Systems—Subpart F Regulations.

- GS1. 438.402 (a, b) Grievance System.
- GS2. 438.402 (3) Filing Requirements—Procedures.
- GS3. 438.404 Notice of Action.
- GS4. 438.404 (b) Content of Notice of Action.
- GS5. 438.416 Record-Keeping and Reporting Requirements.
- GS6. 438.406 Handling of Grievances and Appeals—Special Requirements for Appeals.

The following section provides a detailed assessment of the CareNet's performance in calendar year 2005 as it relates to the operational systems review findings for quality. This year's on-site review included an assessment of all elements and standards, whereas last year, the review focused only on those elements found to be deficient from the previous year.

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population.

All Enrollee Rights and Grievance Systems standards related to quality were met for the CY 2005 review. Only standard one of the 19 Quality Assessment and Performance Improvement standards used to assess quality was partially met, with the remaining standards being met. The determination of partially met for this standard is easily remedied by changing language in current polices to state that the time frame for electronic or written notification must be 14 days instead of 15 for standard authorizations, to be compliant with regulations.

CareNet has a comprehensive Quality Management Plan and Work Plan in place. These documents provided the activities and timeframes for all major quality and utilization management activities to be undertaken in CY 2005. Progress towards goals and objectives were recorded on the Work Plan with progress toward meeting goals and objectives documented through the appropriate Quality Improvement Committees. CareNet has quality monitoring systems in place to assess the quality of care through the use of HEDIS measures, the development and implementation of quality improvement projects, and medical record reviews. The Credentialing program is documented and a review of credentialing files demonstrates that CareNet is ensuring that practitioners in its network meet the required standards.

CareNet performed well in the areas of Enrollee Rights and Protections in the areas of provider, availability of services, provider enrollment and disenrollment, health/management information systems, grievance systems, and handling of grievances and appeals. Policies and procedures were revised for compliance in the areas shown above. An area where CareNet performed successfully in this review is in regards to the availability of services. CareNet has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee. The area of grievance systems was found to be another core strength for CareNet. CareNet has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.

CareNet was found to have opportunities for improvement in the areas of advanced directives and content of notice of action in the CY 2004 review. For advanced directives relating to policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to the enrollee; a recommendation was provided. The recommendation for improvement suggests that CareNet specifically include language in the above policy that identifies how enrollees with be informed about the availability of a no cost second opinion, such as through the Member Handbook. An additional recommendation pertaining to content of notice of action suggests that CareNet Notice of Action (NOA) letter contain the following language relating to benefit continuation and liability for costs of those services "the circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services". These issues were addressed with revisions made to the UM Appeal Process Policy and the Fast (Expedited) Appeal Process for CareNet Members Policy in CY 2005. These standards are now fully met for CY 2005.

CareNet demonstrates a quality-focused approach in administering care and services to its members. The plan exhibits an integrated approach to working with its members, practitioners, providers, and internal health plan departments to improve overall health care quality and services. The health plan also focuses resources toward evaluating the interventions that provide the most benefit toward improvement needs. Only two elements are partially met in the QAPI standards for the CY 2005 review. These elements are related to timeliness and will be discussed in that section.

Summary of Quality

Three HEDIS measures were used as proxy measures for quality; Childhood Immunization Status, Adolescent Immunization Status, and Breast Cancer Screening rates. CareNet exceeded the HEDIS 2005 National average for the Childhood Immunization Status measure, but the Adolescent Immunization Status rate and Breast Cancer Screening rate fell below the Medallion II and the HEDIS 2005 National Medicaid Average. While the Childhood Immunization Status Measure exceeds the HEDIS 2005 National Medicaid Average continuing improvement should be expected in all three measures.

It is important to note that CareNet has a PIP in place targeting improvement in the adolescent immunization rate. If not already in progress, CareNet may want to consider implementing quality improvement projects to address the childhood immunization status and breast cancer screening rates.

The required PIPs have been developed and implemented according to timetables specified by DMAS. The project topics of asthma and adolescent immunization status are relevant and appropriate for the MCO's population. Interventions were implemented in 2005 to address identified barriers. The Adolescent Immunization Combination 2 indicator realized an increase from 20.4% to 26.1% from 2004 to 2005.

CareNet met the requirements for all of the Quality Assessment and Performance Improvement standards related to quality, except for one, in the CY 2005 review which is an improvement over the last review. A revision of the grievance policy in regards to notification timeframes will address the outstanding issue. The appropriate policies and procedures are in place and have been implemented to address concerns identified in the last review, demonstrating the MCO's commitment to quality.

Access at a Glance

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access are described below.

HEDIS

The HEDIS performance measures are used to evaluate access and availability of care through the Prenatal and Postpartum Care results as compared with both the Medallion II and the NCQA HEDIS Medicaid averages. Two rates are calculated for this measure:

- Timeliness of Prenatal Care[3]
- Postpartum Check-up Following Delivery[4]

Table 3 provides the HEDIS results for the Medallion II MCOs for these two measures pertaining to access.

Table 3. Access Measures - Prenatal and Post Partum Care*

Measure	CareNet	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Timeliness of Prenatal Care	85.2%	84.1%	78.3%
Postpartum Care	58.2%	59.9%	55.9%

***Data in this table was submitted by the MCO and not validated by Delmarva.**

[3] Timeliness of Prenatal Care measures the percentage of women in the denominator who received a prenatal care visit in the first trimester or within 42 days of enrollment.
[4] Postpartum Check-up Following Delivery measures the percentage of women in the denominator who had a postpartum visit on or between 21 days and 56 days following delivery.

CareNet's rates for both HEDIS access measures related to prenatal and postpartum care exceeded the HEDIS 2005 National Medical Average. The Timeliness of Prenatal Care measure also exceeds the Medallion II Average. However; the Postpartum Care rate of 58.2% falls slightly below the Medallion II average. The Medallion II Average is also above the NCQA Medicaid HEDIS 2005 Average for both measures.

Performance Improvement Projects

The PIPs implemented by the Medallion II MCOs focused on improvement of clinical indicators. However; within the barrier analyses for each project, potential access barriers also were examined. The following section provides an MCO level specific summary of access issues identified by the Medallion II MCOs through implementation of the PIPs related to asthma.

CareNet's PIP targeted increasing the number of members with asthma receiving care according to clinical guidelines. The PIP also identified access barriers related to member and provider lack of awareness of benefits related to a chronic disease, such as asthma. In 2004, identification and outreach to non-compliant enrollees and targeted case management services for identified high-risk enrollees was implemented to improve member outcomes. In 2005, barriers identified included member and provider knowledge deficits and the need to improve the coordination of care. Interventions implemented included enrolling 137 CareNet members in Asthma Case Management, providing additional interventions for high-risk members (Respiratory Therapist Home environment assessment), providing education through the Community Outreach Team, sending introductory information to newly identified asthmatics, and sending annual provider mailings with a list of their non-compliant members and a description of CareNet's services.

Operational Systems Review

In 2004, as part of a desk-review, Delmarva comprehensively reassessed elements from the previous year's review that previously were not fully met and found that the majority of all elements had improved to a met status. In 2005, Delmarva reassessed all elements and standards as part of the Operational Systems Review. Delmarva's Operational Systems Review of the Medallion II MCOs evaluated elements pertaining to access in the following required review categories. These elements pertain to this and last year's review to provide a complete evaluation of the CareNet's performance in the area of access. The following standards were used to assess the MCOs compliance with access standards.

Enrollee Rights and Protections—Subpart C Regulations.

- ER3. Information and Language Requirements (438.10).
- ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).
- ER7. Rehabilitation Act, ADA.

Quality Assessment and Performance Improvement—Subpart D Regulations.

- QA1. 438.206 Availability of Services (b).
- QA2. 438.206 Availability of Services (b) (2).
- QA4. 438.206 Availability of Services (b) (4).
- QA7. 438.208 (c) 103 Additional Services for Enrollees with Special Health Care Needs.
- QA8. 438.208 (c) (4) Direct Access to Specialists.
- QA10. 438.208 (e) Primary Care and Coordination Program.

CareNet met all the Enrollee Rights and Quality Assessment and Performance Improvement standards above related to access. CareNet performed well in the area of information and language requirements, emergency and post-stabilization services, and the Rehabilitation Act requirements.

Through the pre-site and on-site review conducted for CareNet, Delmarva comprehensively assessed elements for CY 2005. CareNet performed well in areas of access to include an element relating to information and language requirements, emergency and post-stabilization services, the Rehabilitation Act, and direct access to specialists. There was evidence that policies and procedures were revised prior to this review to ensure compliance with standards that were not fully met in the CY 2004 review.

An example of a significant area where CareNet has performed successfully in this review is with information and language requirements, and provision of appropriate and comprehensive member materials to enrollees. CareNet has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs including those who are visually limited or have limited reading proficiency.

In regards to emergency and post-stabilization services, CareNet has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed. These instructions are all provided in the Member Handbook. Another area of strength for CareNet pertains to direct access to specialists. CareNet has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs. In addition, the Precertification Policy allows members direct access to specialists who participate in the CareNet provider network without a referral from their PCP.

CareNet also ensures access to it services through the provision of information through its Member Handbook and Provider Directory. The Member Handbook, which is mailed to enrollees at the time of enrollment, is comprehensive and details the benefits, services, and information members have access to. These services, benefits and information include, but are not limited to, access to out-of-area coverage, procedures for obtaining specialist services, procedures for provider-enrollee communications, a listing of providers that include non-English languages spoken by the providers, enrollment and disenrollment

procedures, complaint and grievance procedures, policies on referrals to specialty care, rights and responsibilities, procedures for accessing the Customer Services Department, and how to obtain member materials in non-English languages and alternative formats.

CareNet also performed will in the area of access to and availability of providers. CareNet has the appropriate access standards in place. Providers are made aware of such standards through provider newsletters and the provider manual. CareNet assesses compliance to these standards at least annually. Specifically, access to primary care, behavioral health, obstetrical/gynecological, urgent and emergency care are assessed. Availability of Primary Care Providers (PCPs), specialty and hospitals is also assessed.

In the CY 2004 review, only one element in the ER domain was partially met and pertained to access. Specifically, in regards to information and language requirements, MCOs must have policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats; a recommendation was provided. The recommended improvement was for CareNet to improve its policies and procedures to include how it will communicate the availability of written MCO enrollee materials information in an alternative formats for enrollees and potential enrollees who are visually impaired or have limited reading proficiency. CareNet revised/implemented two specific policies in CY 2005, Communications Standards for CareNet Members Policy and Communication Barrier Interventions for Care Net Policy, to address the outstanding concerns. CareNet demonstrated its commitment to member access by addressing this outstanding concern within the 2005 review period. All Enrollee Rights standards are fully met for the CY 2005 review.

Summary of Access

Overall, access is an area of strength for CareNet and supports the health plan's intent as a quality-driven system of care. CareNet's performance on the HEDIS prenatal measures related to access exceeded both the HEDIS 2005 National Medicaid average for each measure, demonstrating strength for the MCO. The Medallion II Average is also above the NCQA Medicaid HEDIS 2005 Average for both measures. As in last year's review, these access measures are an area of strength for the MCO.

CareNet developed and implemented PIPs related to asthma and adolescent immunizations which are relevant to its population. CareNet followed the quality improvement project process and implemented additional interventions in 2005 to address identified barriers. The individual antigen rates decreased for MMR and Hepatitis B, but increased for Varicella. Because of the increase in the Varicella antigen (24.7% in 2004 to 30.8% in 2005) the Adolescent Immunization rate increased from 20.4% in 2004 to 26.1% in 2005. CareNet met all of the requirements of the Operational Systems Review related to access. Combining all the data sources used to evaluate access CareNet addressed the areas where the health plan showed vulnerability in the last review and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness at a Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections that follow.

HEDIS

Timeliness of care was investigated in the results of the following HEDIS measures, which the Medallion II MCOs (except AMERIGROUP) were required to submit:

- Well-Child Visits in the First 15 Months of Life[5]
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life[6]
- Adolescent Well-Care Visits[7]

Table 4 provides the HEDIS measure results for the Medallion II MCOs pertaining to timeliness.

Table 4. Timeliness Measures- Well Child Visits and Adolescent Well Care*

Measure	CareNet	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Well Child Visits in the First 15 Months of Life (6 or more visits).	37.7%	47.3%	46.8%
Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life.	60.0%	59.7%	61.9%
Adolescent Well Care.	29.3%	29.6%	40.3%

* The data in this table was submitted by the MCO and was not validated by Delmarva.

The rate for the Well Child Visits in the First 15 Months of Life measure for CareNet was below both the Medallion II Average and the HEDIS 2005 National Medicaid Average. The Medallion II average for this measure was 47.3%, which exceeds the HEDIS 2005 National Medicaid Average of 46.8%.

[5] Well-Child Visits in the First 15 Months of Life measures the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled in the Plan from 31 days of age, and who received six or more well child visits with a primary care practitioner during their first 15 months of life.
[6] Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life measures the percentage of members who were three, four, five or, six years old during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.
[7] Adolescent Well-Care Visits measures the percentage of enrolled members who were age 12 through 21years during the measurement year who were continuously enrolled during the measurement year and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

CareNet's rate for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure was 60.0% which is slightly above the Medallion II Average (59.7%), but below the HEDIS 2005 National Medicaid Average. None of the Medallion II MCOs met or exceeded the Medicaid HEDIS 2005 National Average of 61.9%.

The Adolescent Well Care measure was 29.3% for CareNet. This falls below the Medallion II Average (29.6%) and is well below the HEDIS 2005 National Medicaid Average of 40.3%.

One of the three HEDIS measures that assessed timeliness was below the Medallion II Average, and all three were below the HEDIS 2005 National Medicaid Average. This represents an opportunity for improvement for CareNet.

Performance Improvement Projects

In 2004, timeliness was a focal area of attention in the Medallion II MCO PIPs. Member-focused efforts consisted of member education about the key features of asthma as a chronic disease, routine check-ups, and asthma action plans. An asthma educational packet was sent to newly diagnosed members and medication reminders were sent to members that did not have their asthma controller medications filled in the past year. An Annual Self Care Reminder mailing that included flu shot reminders were also sent to members with asthma. Physician interventions included notifying providers their members with asthma and those that are non-compliant.

In 2005, new interventions were implemented. CareNet identified members with two or more ER visits or inpatient hospitalizations and offered to enroll them into case management services. A respiratory therapist home environment assessment was offered free of charge to help members identify triggers and to provide education to the family on workable interventions. The Annual Self Care Reminders mailing and flu-shot mailings were also completed along with various member educational mailings. Providers also received their annual listing of members with asthma and a listing of non-compliant members with asthma.

Issues related to timeliness of services may very likely be affected by access. The Medallion II MCO PIPs, aimed at improving important asthma performance measure, use HEDIS methodology and target services received (access) as well as on the time frame in which the services were provided (timeliness).

Operational Systems Review

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate CareNet's commitment to timeliness of services.

Delmarva's operational systems review of the Medallion II MCOs assessed and documented elements pertaining to timeliness in the following review requirement categories. These elements pertain to the 2005 and last year's review to provide a complete evaluation of the Medallion II MCOs performance in the area of timeliness. Standards used to assess the Medallion II MCOs compliance with timeliness are included below.

Enrollee Rights and Protections—Subpart C Regulations.

- ER2. Written Statement Upon Enrollment.
- ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (Privacy and Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996.

Quality Assessment and Performance Improvement—Subpart D Regulations.

- QA9. 438.208 (d) (2) (ii-iii) Referrals and Treatment Plans.
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests.
- QA12. 438.210 (c) Coverage and Authorization of Services—Notice of Adverse Action.
- QA13. 438.210 (d) (1) Timeframe for Decisions—Standard Authorization of Decisions.
- QA14. 438.210 (d) (2) Timeframe for Decisions—Expedited Authorization Decisions.

Grievance Systems—Subpart F Regulations.

- GS7. 438.408 Resolution and Notification: Grievances and Appeals—Standard Resolution.
- GS8. 438.408 Resolution and Notification: Grievances and Appeals—Expedited Resolution.
- GS9. 438.408 (b-d) Resolution and Notification.
- GS10. 438.408 (c) Requirements for State Fair Hearings.
- GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions.

CareNet met the requirements for all of the standards related to timeliness listed above, except for on Quality Assessment and Performance Standard (QA 13). The time frame for electronic or written notification of standard authorizations must be changed to 14 days instead of 15 for its procedures to be compliant with regulations.

CareNet performed well in the areas of privacy protection and the Health Insurance Portability and Accountability Act of 1996, timeframe for decisions—standard authorization decisions and expedited authorization decisions, resolution and notification, requirements for state fair hearings, and expedited resolution of appeals.

There is one area, timeliness of notification that was identified in the CY 2005 review as requiring policy change to meet standards. The standards require the MCO's to provide a decision and notice as expeditiously as the enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for

service, with possible extension up to 14 additional calendar days if enrollee requests an extension or the MCO justifies a need for additional information. CareNet policies state that written or electronic notification of a denial decision is given to the member in 15 days. CareNet must revise the appropriate policies to state the timeframe as 14 days per the requirements. Timeframes for authorizations, resolutions and notifications are tracked and monitored for timeliness to completion and measured for compliance against CareNet's internal standards. This monitoring demonstrates that although the policy notes 15 days, CareNet meets the 14 day time frame in practice.

CareNet has the required policies/procedures relating to the extension of time frames for expedited authorizations allowed under the state contract. Another area of strength for CareNet relates to resolution and notification. CareNet has a process for extension, and for notifying enrollees of reason for delay. CareNet makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and provides follow-up within two calendar days with a written notice of action. Providers are notified via telephone when possible to allow for timely feedback of authorization decisions.

Delmarva identified two elements pertaining to resolution and notification and requirements for state fair hearings that were found to be partially met in the CY 2004 desk review. A recommendation for resolution and notification pertaining to decisions by the MCO to expedite appeals in writing and include decision and date of decision is for CareNet to revise the Southern Health Policies and Procedures: Fast (Expedited) Appeal Process for ?CareNet Members policy was provided. Revision of this policy would include the requirement for date of appeal decision in the written notification to the enrollee. The final recommendation in regards to requirements for state fair hearings is for CareNet to revise the three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members to include time frame for delivery of the monthly appeals report to DMAS as well as required report content. These policies and procedures were modified as recommended and therefore this concern was resolved in CY 2005.

CareNet demonstrated its commitment to timeliness though the monitoring systems it has in place. Timeliness for decision making and notifications for authorizations and grievances and appeals are in place. Although one time frame does not meet the requirements, CareNet meets the time frame in practice.

Summary of Timeliness

In regards to timeliness, only one of the three HEDIS measures (Adolescent Well Care) that assessed timeliness was below the Medallion II Average. However; all three were below the HEDIS 2005 National Medicaid Average. This represents an opportunity for improvement for CareNet.

In 2004, timeliness was an area of attention in regards to PIPs. This continued in 2005, when many of the same barriers noted in the asthma project were encountered with new interventions developed and/or implemented to address these barriers. Interventions included implementing a Chronic Disease program and Department and adding additional case management staff.

CareNet met all requirements for the Enrollee Rights and Grievance Systems standards used to assess access. Only one of the six Quality Assessment and Performance Improvement standards was not met and only requires a policy change in the number of days required to provide standard authorization decisions.

Overall Strengths

Quality:

- CareNet exceeded the HEDIS 2005 National average for the Childhood Immunization Status measure.
- CareNet has experienced an increase in its Adolescent Immunization Combination 2 Rate project from the baseline rate to 2004.
- CareNet fully met the requirements for all Enrollee Rights and Grievance Systems standards used to assess quality for this review.
- Eighteen of the 19 Quality Assessment and Performance Improvement standards used to assess quality were met.
- There is a demonstrated commitment of CareNet management staff towards quality improvement as evidenced by the continued attention to resolving issues identified in the annual review.
- CareNet information systems capabilities are capable of providing timely, accurate, and complete information about the Medallion II program.
- CareNet has a comprehensive Quality Improvement Program document and Work Plan in place to guide the annual quality improvement activities.
- Quality improvement and focused studies are in place and are appropriate for the MCO's population.
- The Credentialing Program is in place and functioning well.

Access:

- The two HEDIS measures used as proxies for access, Timeliness of Prenatal Care and Postpartum Care exceeded the HEDIS 2005 Medicaid National Average.
- The Timeliness of Prenatal Care measure exceeded the Medallion II average.
- CareNet fully met the requirements for all three Enrollee Rights and six Quality Assessment and Performance Improvement standards used to assess access for this review.
- The MCO's PIP focusing on asthma included interventions specifically targeted to improve access to the program. These interventions included individual contact with members.
- CareNet has systems in place to monitor access and availability to providers in its network.

- Member Materials are comprehensive and provide members with appropriate level of detail to ensure access to services.
- CareNet improved its policies and procedures to include how it will communicate the availability of written materials in alternative formats for those with visual impairments or limited reading proficiency.

Timeliness:

- One of the HEDIS measures used as a proxy for timeliness, Well Child Visits in the First 15 Months of life (6 or more visits), exceeded the Medallion II average.
- The Asthma PIP addressed member and provider knowledge deficits, non-compliance with treatment plans, and timely information for physicians on their non-compliant members. Interventions were developed to address these barriers and included offering a home environmental assessment by a respiratory therapist free of charge, enhancing the Asthma Case Management program to include members who have had two or more ER visits or an inpatient hospitalization, member and provider newsletter articles on aspects and treatment of the disease, and annual mailings of asthma educational mailings and flu shot reminders.
- CareNet's policies and procedures that include timeframes for completion of tasks (e.g. complaint and grievance resolution time frames, authorization decisions etc.
- Timeframes for completion of tasks is monitored through the Quality Improvement channels for compliance.
- There are procedures in place to accommodate requests for expedited requests (expedited appeals, expedited authorizations etc).
- CareNet fully met the requirements for all Enrollee Rights and Grievance Systems standards used to assess timeliness.
- CareNet met all but one of the six Quality Assessment and Performance Improvement standards used to assess timeliness.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for CareNet are as follows:

HEDIS measures can provide an MCO with valid and reliable data for planning purposes. The HEDIS measures used as proxies for quality included Childhood Immunization Status (Combination 2), Adolescent Immunization Status (Combination 2), and Breast Cancer Screening. CareNet only exceeded the HEDIS 2005 National average for the Childhood Immunization Status measure. All other measures fell below this average and also below the Medallion II average. While the Childhood Immunization Status Measure exceeds

the HEDIS 2005 National Medicaid Average, there is still room for improvement for all three measures. It is therefore recommended that CareNet continue its participation with the other Medallion MCOs in the collaborative project to improve immunization rates. It is also recommended that CareNet further investigate the need for a project on breast cancer screening or at a minimum conduct a barrier analysis.

All three HEDIS measures used as proxies for timeliness were below the Medallion II and HEDIS 2005 Medicaid National Average, except for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure which exceeded the Medallion II rate by one tenth of one percentage point. It is clear that CareNet should review these access measures and determine the need for a quality improvement project related to well child and adolescent well care visits.

PIPs currently include one on the topic of asthma and a newly implemented project on adolescent immunization status. Although the Adolescent Immunization Status Combination 2 measure increased from 2004 to 2005, two of the individual antigen rates (2nd MMR and 3 Hepatitis B) decreased. It is necessary for the MCO to complete another barrier analysis and an assessment of the effectiveness of its interventions to address these barriers and formulate targeted interventions. After this review and analysis, it is important for the MCO to modify or implement additional interventions to address the barriers identified.

Only two of the Quality Assessment and Performance Improvement standards used to assess CareNet for the annual review were not fully met and relate to timeliness for electronic or written notification for standard authorizations. Policies and procedures must adhere to the 14 day requirement. To be compliant with regulations, CareNet must change its 15 day notification allowance to a 14 day requirement to be compliant with regulations.

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